Idaho Ryan White Medical Case Management ANNUAL RECERTIFICATION

PERSONAL/CONTACT INFORMATION

Legal Last Name:	Legal First Name	rst Name:		MI:	
Address:			City:		
County:		State:	Zip Code:		
Mailing address if different from above:	Social S	ocial Security Number:			
Phone (H) () (W) () Cell/Pager ()					
Emergency Contact/ Legal Guardian: Phone () Aware of HIV+ Status: \Box Y \Box N					
Client Preference for Contact: phone phone message office visit mail email ()					
Can talk to: 1) 2)					
Are there any concerns related to the above contacts? If yes, please explain.					
Preferred Language:	Interpreter Needed? ☐ Yes ☐ No				
HIV STATUS					
Since your last recertification, have you been diagnosed with AIDS? Yes No NA Date of diagnosis://					
Medical Status: Current CD4: (□ Self-Report □ Medical Records □ Estimated) Date of test: / /			1)	currently ed ARVs?	
HIV Care Provider: Name: Phone: ()					
Clinic Name:					
Address:					

INSURANCE INFORMATION

Do you have private health insurance? ☐ Yes ☐ No					
If yes , is your health insurance through your current or previou	s employer? 🗆 Yes 🗆 No				
If through previous employer, date COBRA Co	overage began://				
If yes , does your health insurance cover medications? \Box Yes	□ No				
If yes , is there a total expense limit for medications?	⊐ Yes □ No				
Patient Insurance Information:					
□ Patient □ Guarantor (Name:) Birth Date of Ins	ured://			
Address (if different from above) City & State, Zip Code:					
Home Phone: () Work Phon	e (if applicable): ()				
Name of Primary Insurance: □ Uninsured □ Blue Cross □	Name of Primary Insurance: ☐ Uninsured ☐ Blue Cross ☐ Blue Shield ☐ Idaho Physicians Network				
□ Medicaid □ Medicare □ Tricare □ VA/CHAMPUS □ A	pplied for Medicaid (Date:	/)			
□ Other (specify)					
FINANCE INFOR	MATION				
	(For state office use only)				
Annual Gross Household Income:	Percent Poverty Level				
Individual Annual Gross Income:	□ Copy of Income Documentation				
	□ Copy of Photo Identificatio				
Household/ Family Size:	□ Copy of Insurance Card (fro				
HOUSING ST.		·			
Most Recent/Current Housing Status: ☐ Stable/ Permanently Ho	The state of the s				
☐ Unstable ☐ Other (specify)	🗆 🗆 Unknown/l	Unreported			
Please indicate information has been gathered and shared by having cl					
Informational Forms (client provided copies and time for questions & a	Client's Initials				
Client Rights and Responsibilities					
Complaint Grievance Procedures					
What You Need to Know About Idaho Laws on HIV					
Acknowledgement of Notice of Privacy Practices (agency specific)					
Other:					
Client Acknowledgement:	1				
As a partner in this process, I acknowledge that:					
1) The above information is true to the best of my knowledge ()					
2) The purpose of my participation in medical case management is to					
3) I will notify my medical case manager of any change in my health in	surance status, financial situation,	, income, or living			
arrangements ().					
4) I authorize this agency to share information and to coordinate care					
This program involves the receipt of federal and/or state funds; any federal criminal prosecution, which may result in fines, imprisonme		=			
suspension from RWPB Programs and ADAP ().	ne, or both. Additionally, there wil	is be an automatic six month			
Client/Guardian Signature	Date				
Medical Case Manager Signature Date					